governance, funding of sexual health services, BMA AIDS foundation, "Access to clinics" report for CMO, liaison with FFPRHC, and reciprocal CME.

The Sexual Health and HIV Strategy due to report in early 2001 may have a significant impact on services providing sexual health care. The challenge for our specialty is to be at the forefront of these changes, being part of the broader picture and outward looking into the communities which we serve, in contrast to a more passive approach of waiting for the "at-risk" population to come to us. This requires a critical look at the way services are provided at present and opportunities for providing them in a more efficient way. Our strengths, particularly with regard to health promotion, partner notification, accessibility and skills in communicating with young people, need to be increased and marketed. We are fortunate to have at the helm of MSSVD an extremely proactive president with strategic vision and a grip on operational aspects of running sexual health services. I am delighted that the work which has been undertaken over the 4 years since I have been Honorary Secretary will continue, be refined, and changed according to political imperatives and the needs of people accessing our services. I wish Keith Radcliffe as my successor good fortune and thank him and the treasurer and president for all the help and encouragement that they have proffered over the last year.

Finally, my thanks to all fellows and members for their continuing support to the MSSVD and to me personally over these past 4 years.

ANGELA J ROBINSON
*Honorary Secretary*

# LETTERS TO THE EDITOR

## Papulonecrotic tuberculide of the glans penis

EDITOR,—A 27 year old promiscuous, married man presented with recurrent episodes of ulceration of the penis of 12 years' duration. Each episode began with a painful small raised lesion which got ulcerated and finally healed spontaneously in 2–3 months. The present episode of painful ulceration had been lasting for 6 months or so. In spite of various treatments received from various private practitioners, his genital sore did not respond.

On physical examination, this moderately nourished individual had a single well defined ulcer on the glans penis near the urethral meatus, measuring 8 × 5 mm. The edge of the ulcer was undermined and its floor had necrotic slough. The ulcer had perforated deeply into the urethra, resulting in dribbling of urine through it (fig 1). Multiple puckered scars over the glans penis circumferentially, just distal to the coronal sulcus, were evidence of previous episodes of similar ulcerations. The inguinal lymph nodes were not significantly enlarged. His systemic examination was unremarkable.

*Figure 1 Glans penis showing both ulcer and puckered scarring.*

The haemogram revealed a raised erythrocyte sedimentation rate (64 mm in the first hour). The Mantoux test was strongly positive (20 × 20 mm). VDRL and HIV serology was non-reactive. Radiological investigations did not demonstrate any focus of tuberculosis in the chest or genitourinary system. Smear and culture of discharge from the ulcer and also of urine for acid fast bacilli were negative. Histopathological examination of the ulcer (glans penis) revealed ulcerated epidermis. In the deep dermis, by the side of the ulceration, there were caseating tuberculous granulomas along with perivascular inflammatory infiltrate with vessel wall thickening and endothelial cells swelling. Fite's stain for acid fast bacilli was negative. These features were consistent with the diagnosis of papulonecrotic tuberculide. The patient was treated with a four drug regimen for antituberculous therapy to which he responded favourably. At the end of 2 months, the ulcer had healed completely.

Even though it is considered to be rare, tuberculosis of the penis may manifest as primary, secondary, or papulonecrotic tuberculide type.[1–4] Clinically, it may present as superficial ulcers of the penis or tuberculous cavernositis.[2] Papulonecrotic tuberculide, a form of cutaneous tuberculosis, represents an allergic reaction to bursts of antigens reaching highly immune skin following haematogenous spread from an internal focus. The tuberculous focus is often not clinically active at the time of eruption[5] as seen in our case. The diagnosis of papulonecrotic tuberculide in our case was based on the well laid down criteria.[3 4]

Papulonecrotic tuberculides are mostly extragenital, but rarely genitalia may be involved.[3] Sometimes, the glans penis alone may be involved as in our patient and then diagnosis becomes difficult. Under these circumstances, it needs to be differentiated from atypical soft sore, syphilis, recurrent herpes simplex, and malignant ulcer.[4] The diagnosis of such cases rests on biopsy, tuberculin testing and, in doubtful cases, a therapeutic test is usually decisive.[1–4] The possibility of tuberculosis as a cause of chronic ulcer on the penis has to be kept in mind especially in countries like India, where tuberculosis is still prevalent.

*Contributors:* MV wrote the manuscript; DMT was involved in planning and execution of the manuscript; PKK took part in the management of the case and literature search

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## Attitudes to lesbians and homosexual men: medical students care

EDITOR,—We read with interest the article by Fethers and colleagues on STIs and risk behaviours in women who have sex with women (WSW) and the accompanying editorial by Marrazzo.[1 2] It is gratifying to see our own results[3] replicated in a larger and more complete study. Marrazzo highlights many of the methodological difficulties and deficiencies in research into WSW and comments specifically on " lack of interest" or homophobia contributing to the paucity of interest into STI risk among WSWs. Homophobia is recognised as a barrier to accessing health care.[4] We wish to report encouraging attitudes among the majority of medical students but forewarn colleagues of the potential for difficulties with attitudes in a minority of medical students.

Over the past 3 years we have administered the "Attitudes to lesbians and gay men" questionnaire[5] to final year medical students at St Bartholomew's and the London Medical School as part of core teaching on "sexuality and sexual health," in order to promote discussion. This consists of two 10 item subscales for assessing heterosexual attitudes to homosexual men and lesbians. The 20 statements are presented in Likert format with a nine point scale ranging from "strongly disagree" to "strongly agree," therefore scores range from 20 (extremely positive attitudes) to 180 (extremely negative attitudes). We have analysed the responses to 217 questionnaires: 41% of the sample were male and the median age was 23 (range 21–34 years). The

*Table 1 Mean total and subscale scores for Attitudes to Lesbian and Gay Men (ATLG) Questionnaire*

| | *Male (n=86)* | *Female (n=123)* | *p Value* |
|---|---|---|---|
| ATLG mean (range) | 69.0 (20–176) | 56.0 (20–142) | 0.003 |
| ATG* mean (range) | 40.9 (10–90) | 31.8 (10–62) | <0.001 |
| ATL† mean (range) | 28.4 (10–90) | 24.2 (10–80) | 0.03 |

*ATG = Attitudes to Gay Men.
†ATL = Attitudes to Lesbians.

results are presented in table 1. The majority of the sample displayed positive attitudes to lesbians and homosexual men with female students exhibiting statistically more positive views especially in relation to homosexual men. However, a significant minority of men (11.8%) exhibited extremely negative attitudes to homosexual men.

We are encouraged by these results which are contrary to much of the published data on attitudes among physicians, nurses, and medical and non-medical students. However, we must continue to challenge negative attitudes as studies show that teaching and promoting tolerance can result in change.[6] Otherwise difficulties with disclosure in medical settings will continue to impact on provision of health care to WSW and homosexual men and further hamper research in this area.

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### Questionnaires and postal research: more than just high response rates

EDITOR,—In the recent editorial by Bates and Rogstad[1] the authors describe the problems associated with conducting postal research including response rates, use of incentives, bias, mailing clinical specimens, and ethical issues. We would like to add that there are other important issues to consider when undertaking questionnaire research.

The effectiveness of incentives to increase response rates remains controversial. Kalantar and Talley[2] recommend using a lottery incentive as it increases response rates after the first mailing. However, differences between groups were not large, and decreased during follow up and disappeared by the fourth mailing. Koloski *et al*[3] found that the use of lottery tickets increase response rates, but may be limited when using them with long questionnaires (32 pages). Moreover, they compared the length of questionnaire (28 *v* 32 pages) which, while being different, did not reach statistical significance.

The most important aspect of postal research is the questionnaire itself! While high response rates are desirable, it is critical that the information provided by participants is of high quality. The quality of the data may differ between short and long questionnaires and to our knowledge this has never been validated. When participants fill out a long questionnaire they may rush or mark incorrect responses purely because they have lost interest because of the length of the questionnaire. Conversely, if a questionnaire is too short, it may be deemed "unimportant" and not worth completing.

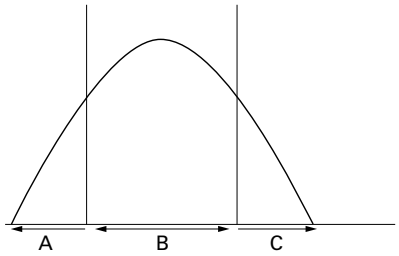


*Figure 1 A theoretical model of how response rate may perform according to questionnaire length*

The real question is, is there any real difference in the size of the length of the questionnaires used in this study? In comparison with a four or 10 page questionnaire they are still long. Studies are lacking which highlight the threshold or optimal length of questionnaires.

Figure 1 shows a theoretical model of how response rate may perform according to questionnaire length. Part A represents low response rates due to questionnaires of short length; part B is the optimal questionnaire length giving the best response rate; and part C shows the poor response rate due to questionnaires of excessive length.

The presentation of the questionnaires will also influence the response rates to postal surveys. Questionnaires that are professionally printed and designed are more likely to be taken seriously by participants compared with two pages stapled together.

Other reasons for an increased response rate include the importance of assuring participants of their confidentially and this can improved even further if the steps taken to keep subject data confidential is explained. Respondents may want or expect their answers to be treated strictly in confidence, especially if the topic area is threatening or embarrassing. The researcher should not promise greater confidentiality than he/she can provide remembering that coders and data processors may have access to the information.

Ethics of repeated follow ups is of concern. Some individuals do not like receiving multiple mailouts and this can be a problem if they complain. The respondents' privacy and dignity should be respected. A dilemma may sometimes arise when the need for the researcher to obtain the "informed" consent of respondents conflicts with the need for respondents not to know so much that the results are biased.

One thing is certain; the greater the number of follow ups completed the higher the response rate will be. There can be problems associated with undertaking multiple follow ups, particularly when individuals complain about the number of letters and/or questionnaires they receive. However, this can easily be solved by stating on the initial cover letter if they do not wish to be contacted further, to contact the researchers and tell them so they can be removed from the mailing list. By using some of these techniques researchers should be able to obtain increased response rates and higher quality questionnaire data.

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### Genital herpes may mask underlying neoplasia

EDITOR,—Lesions that fail to heal despite appropriate therapy should always be biopsied to look for an underlying diagnosis. We have seen a 44 year old woman who presented with genital ulceration and lichen sclerosus and was culture positive for herpes simplex virus (HSV) type 1. After treatment with two courses of oral aciclovir there was some reduction in ulceration and resolution of symptoms. However, in view of the persisting solitary ulcer and the presence of lichen sclerosus (fig 1) a biopsy was performed. Histology was reported as showing poorly differentiated invasive squamous cell carcinoma with vulval dystrophy but no features of wart virus infection. She was promptly referred to the gynaecological oncology department where local radiotherapy and chemotherapy were the initial treatments of choice as the tumour extended close to the anal margin. The immediate response was encouraging but subsequently vaginal adhesions and difficulty with micturition developed. A pelvic CT scan showed bilateral inguinal node involvement (fig 2). Radical block dissection was subsequently performed but lymphoedema and local skin nodules developed and she died 2 years after diagnosis.


*Figure 1 Appearance of the vulva—ulceration remains despite therapy for HSV. Note white plaques, small haemorrhages, and labial resorption typical of lichen sclerosus.*